

Preferred Dental Plan

Association Group Dental Insurance
Form DNT 710
Underwritten by American Pioneer Life Insurance Company

A voluntary plan offered through United Specialty Association Corp (USA Corp)
1-800-351-2333

How Do I Enroll?

1. Select the insurance package that fits your needs (Example: "Member & Family").

2. Complete the attached Enrollment Form. (Completion of attached Enrollment Form includes Membership in Benefits Association)

3. Select mode of payment.

4. Enclose a check for one month premium made payable to American Pioneer Life.

5. Questions concerning benefits or enrolling? Call: Toll Free: 1-800-351-2333

Dental Facts

"Most dental disease can be avoided through preventive care and good oral hygiene."
The American Dental Association

"Every year one of ten people experiences a restricted activity day or lost work day due to dental disease."
National Center for Health Statistics

"Tooth decay and other dental diseases affect nearly 95% of the population."
American Institute of Preventive Medicine

The continuing rise in the cost of dental care has made dental insurance an important consideration for today's American families.

Now you and/or your family are eligible for this New Voluntary Dental Plan

And you select your own dentist.

As a Member of the

Benefits Association

you will receive the following benefits & services:

PreScrip

Prescription Drug Benefit Program

Avesis

Receive discounts on comprehensive hearing exams and hearing aids

Vision One

Eyecare program save on eye examination and contact lenses

PreScrip

Prescription Drug Benefit Program

The Worldnet

World Wide Travel Assist Program

Dental Care Description

Preventive*

- Oral Examination
- Cleanings
- Topical flouride to age 19 once in a 12 month period

Diagnostic*

- Bitewings x-rays once each policy year
- Full mouth x-rays once every 3 years
- Sealant application to posteria permanent teeth once in a 36 month period
- Space maintainer for baby teeth to age 16

Basic Care*

- Restorative Services (fillings)
- Extractions
- Oral Surgery
- Related anesthesia Treatment
- Prescription for control of pain

Major Care*

- (A) Endodontic Procedures and Periodonic Services
- (B) Prosthodontics, Inlays, Crowns and Post, Dentures & Bridges**
- (C) Orthodontia Dependent Children ages 6 to 19***

*$1200 policy year maximum benefit per person for all services combined.
$600 policy year maximum benefit per person for Major Care (B) Services for insureds over 64 years old. *$350 policy year maximum benefit per person and $1,000 maximum Lifetime benefit for Major Care (C) Services.

How the Plan Pays

One-Time $100 Deductible per Insured's Life Time	Year		
	1	2	3
Preventive	80%	90%	100%
Diagnostic Care	70%	80%	90%
Basic Care	60%	70%	80%
Major Care	0%	40%	50%

Monthly New Business Rates

Area	ZIP Code (First three digits)	Member	Member Plus One	Member and Family
1	AL, AR, MS, MO, OK, TN	$42.77	$81.49	$113.90
2	GA, LA	$45.17	$86.34	$120.77
3	AZ, KY, NM, TX	$47.60	$91.19	$127.62
4	CO, FL	$50.01	$96.02	$134.50

The above amounts include Association membership dues of $1.00 and a billing fee of $3.00

Why The Preferred Dental Plan?

- Choose Your Own Dentist
- A Dental Plan with a $100 Lifetime Deductible
- Keep your Dental Plan regardless of Your Age
- Ortho Benefits Included at No Extra Charge
- Benefits Increase for the First Two Years
- No Questions about your Past Dental History
- Annual Maximum of $1200

EXCLUSIONS AND LIMITATIONS

Preventive/Diagnostic Benefits (Type I Procedures), Basic Benefits (Type II Procedures), Major Benefits (Type III Procedures) and Orthodontic Benefits.

Payment will not be made for: 1) Charges Incurred: a) prior to the Effective Date the Insured became covered under the policy; b) prior to the end of any applicable benefit waiting period indicated on the schedule of benefits; or c) following termination of coverage. 2) Dental care not included in the list of dental procedures. 3) Charge for a dental treatment, service or supply not provided by a Dentist, except a) A dental treatment, service supply provided by a licensed dental hygienist under the supervision of a dentist; or an x-ray order by a Dentist. 4) Dental care for which the person would not be required to pay if there were no insurance. 5) Replacement of a lost or stolen prosthetic device. 6) Charges Incurred for the treatment of temporomandibular joints dysfunction syndrome (TMJ). 7) Root canal therapy if the pulp chamber was opened before the Effective Date of the Insured. 8) Charge for a service that involves: a) an appliance or change in an appliance for which the impression was made. b) a crown or bridge for which a tooth was prepared. c) root canal therapy for which the pulp chamber was opened, or d) and orthodontic services which began prior to the Effective Date of the Insured and prior to the end of the applicable Waiting Period. 9) Dental care provided only for the purpose of improving appearance (cosmetic dentistry), when form and function of the teeth are satisfactory and no pathological condition exists. 10) Dental care that is: a) Not Medically Necessary; b) Are not recommended and approved by a Dentist; or c) below the standards accepted by the American Dental Association. 11) Charges in excess of the Usual and Customary charge for the least expensive alternate service or material consistent with adequate dental care. This applies when such services or materials are customarily provided. 12) Charges for appointments not kept, office calls if no service was performed and charges for completion of claim forms. 13) Charges relating to dental care directly or indirectly caused by: a) War, insurrection, or hostile action of the armed forces of any country. b) Any cause for which indemnity or compensation is provided under any Worker's Compensation Law, Labor Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans, or Employee Benefit Organization Plans. 14) Charges for a full or partial denture or bridgework, unless: a) Such denture or bridgework replaces one or more natural teeth extracted while the patient is insured under the policy; or b) Such denture or bridgework is a replacement for another denture or bridge and the replacement occurs more than a year after the patient first becomes insured under the policy for dental benefits and more than five years after the date of last placement. 15) Services provided or paid for by any government agency or under any government program or law, except as to charges that the person is legally obliged to pay. The excepetion extends to any benefits provided under the U.S. Social Security Act of 1965 (Medicare) and its amendments. 16) Charges incurred while in a Hospital. 17) Charge for any procedure that is medical in nature or covered under a medical plan. 18) Charge incurred outside the United States. 19) Expenses resulting from any attempt at suicide or any other intentionally self inflicted injury.

AMERICAN PIONEER LIFE INSURANCE COMPANY
ENROLLMENT CARD

MODE OF PAYMENT

Social Security No.	Last Name First Initial (Primary Insured)	Birthdate	❑ M ❑ F
Home Address	Street		
Phone ( )	City State Zip		

❑ Annually ❑ Quarterly ❑ Monthly (by Bankdraft Only)
❑ BANKDRAFT This is authorization to draft payments from my checking account. A voided check is enclosed on the bank on which drafts are to be drawn.
OR ❑ Charge Premiums to: ❑ Visa ❑ Mastercard
Credit Card# _____
Exp. Date _____ / _____

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different) First Initial	Birthdate	Sex
2 Spouse		
3 Dependent		
4		
5		
6		
7		

Question: 1) Are all dependent children applicants between the ages of 19 and 25 full-time students (Y/N) If no, then which child(ren) are not full-time students? _____

"I understand and agree that (I) the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate and (2) the agent does not have the authority to make or alter any contract or waive any of the Company's other rights or requirements."

Applicant's Signature _____ **Date** _____

AEC-DNT 2/99

351000

AGENT NAME: AGENT SIGNATURE:

AGENT #

Make Check for 1st month payable to **American Pioneer Life Insurance Co.** even if you choose monthly Bank Draft or Credit Card payment. **Return all Enrollment Material to:**

United Specialty Associates Corp (USA Corp), 5600 Northwest 102nd Avenue • Suite M • Sunrise, FL 33351